State of Utah
Department of Human Resource Management

APPLICATION FOR FAMILY MEDICAL LEAVE

Employee Name: _____
Employee's Full Name

Agency/Dept: _____ Division: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Start Date of Anticipated Leave: _____ Expected Date of Return to Work: _____

Reason for Leave (Explain): _____

NOTE: A leave request based on an employee's serious health condition or the serious health condition of an employee's spouse, child, or parent must be accompanied by a verifying medical certification from a physician.

I hereby authorize my employer, the State of Utah, to contact my physician to verify the reason for my requested leave or for any other information concerning my requested family and medical leave.

Physician name: _____ Telephone: _____

I understand that failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by my employer. If I am able and elect not to return to work I will be required to reimburse health plan payments made by the State of Utah.

Employee's Signature: _____ Date: _____

This section to be completed by the Department

Supervisor Approval: _____ Date: _____

Agency HR Director Approval: _____ Date: _____